CareSignal®

Deviceless Remote Patient Monitoring

Deviceless Remote Patient Monitoring in a Robust Virtual Care Strategy

Why the Right RPM Strategy Can Be Scalable…
Without Sacrificing Clinical Actionability and ROI

Blake Marggraff | CEO, CareSignal | blake@caresignal.health

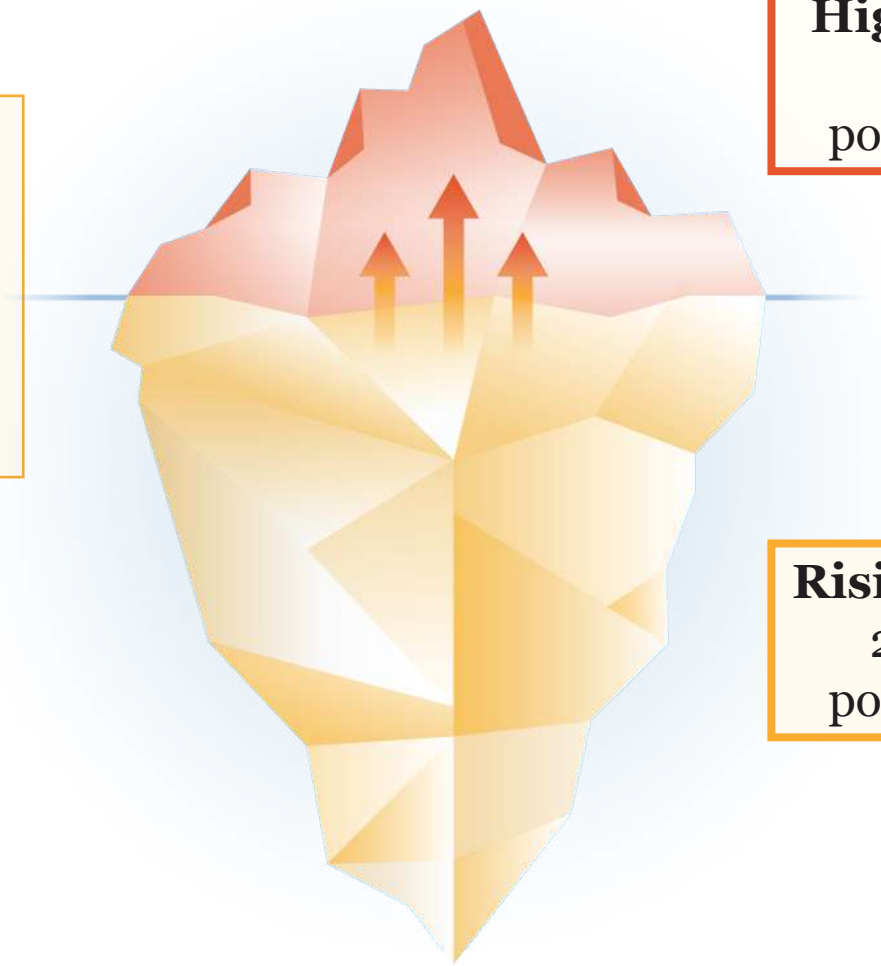
Today's Agenda

- Examine industry leaders' models for the Virtual Care landscape
- Define a new category of Remote Patient Monitoring: *Deviceless Remote Patient Monitoring*
- Review Large Provider & Payvider Case Studies
  - Use-cases including Chronic *and Behavioral* Health
  - Engagement
  - Clinical Outcomes & Financial Returns
  - Patient Satisfaction

CareSignal™

True Population Health Has Never Been More Vital

Each year, 1 in 5 of rising-risk patients become expensive, high-risk patients



High-Risk: 5% of population

Rising-Risk: 20% of population

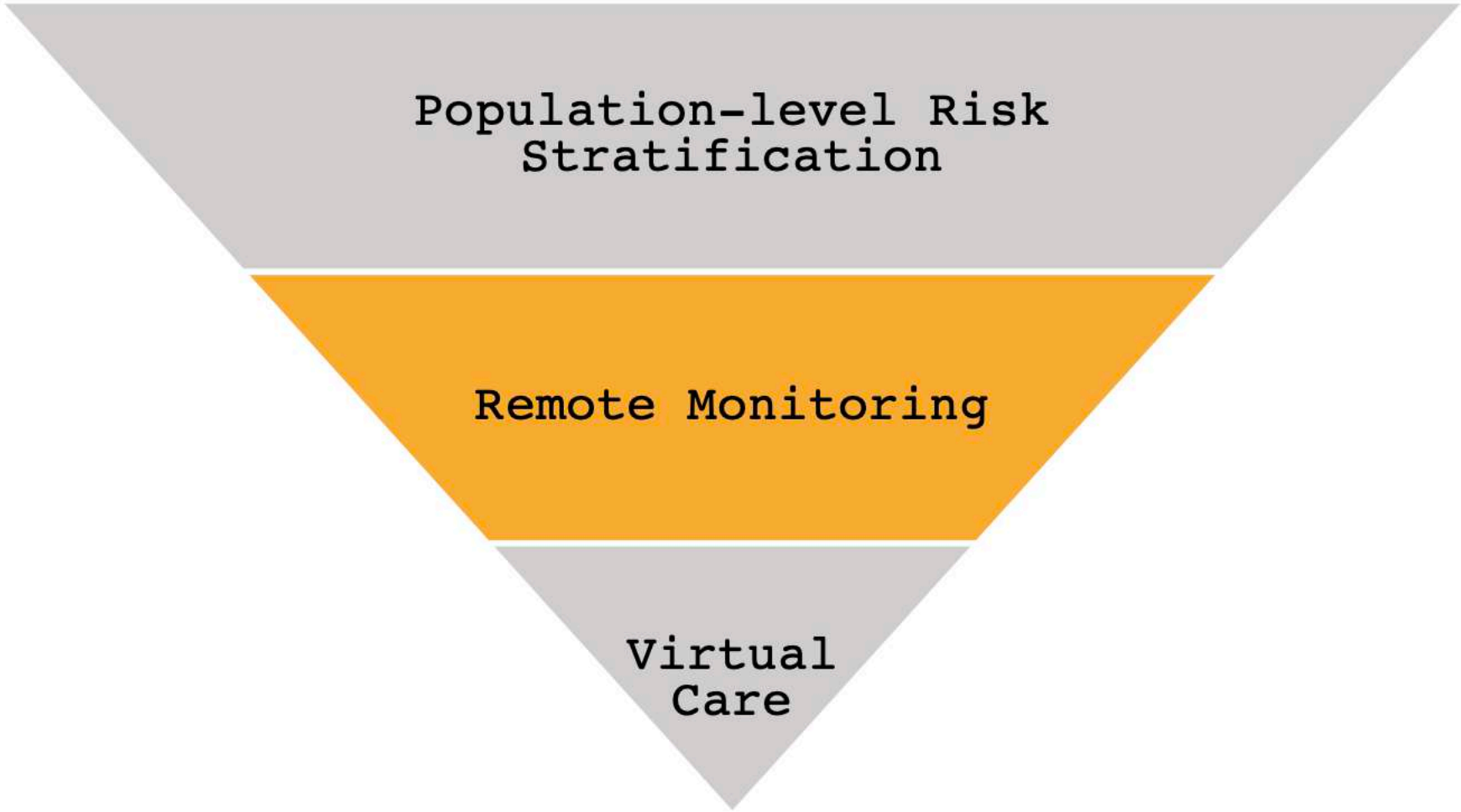
The NEW ENGLAND JOURNAL of MEDICINE

*"Our findings may also reflect fundamental challenges with the strategy of targeting superutilizers: **many [members] whose medical costs are high today will not be as high in the future**." – Hotspotting Study*

(A. Finkelstein et al., 2020)

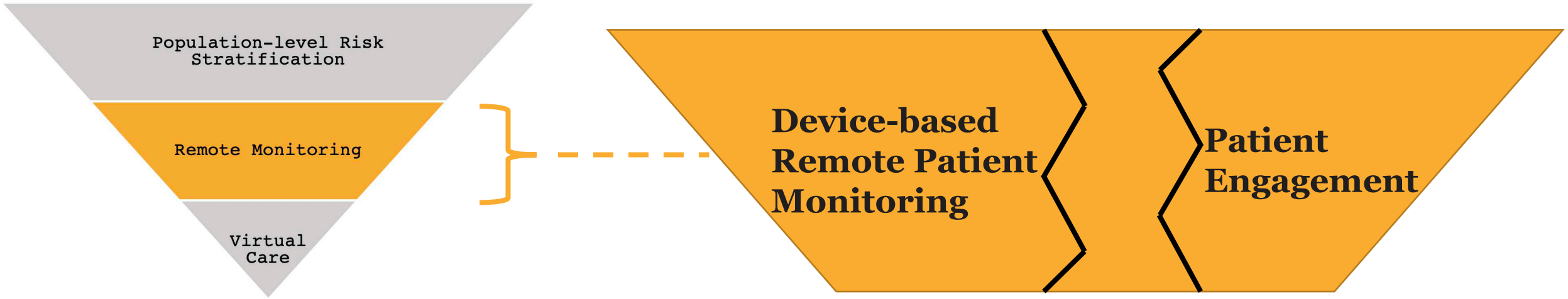
CareSignal™

Where Does Remote Monitoring Fit?



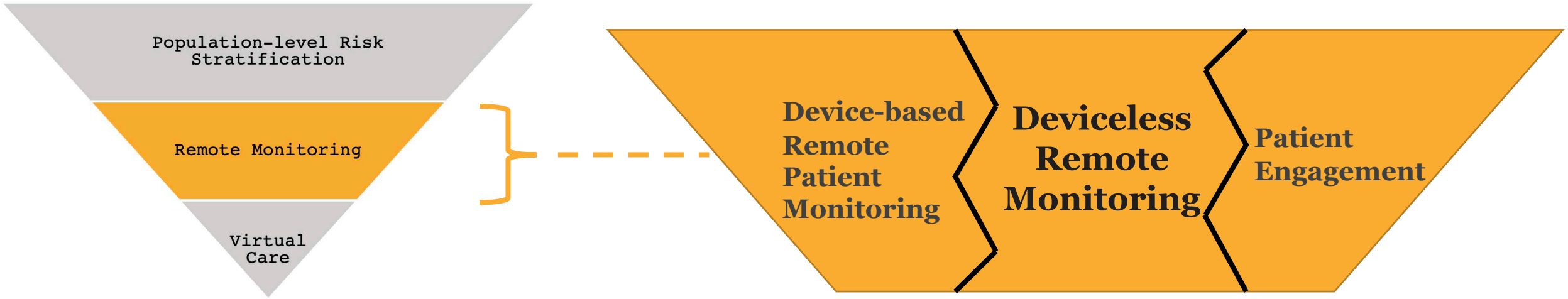
CareSignal™

And What *Is* Remote Monitoring?



CareSignal™

Where Does Remote Monitoring Fit?



CareSignal™

Deviceless Remote Monitoring
Evidence-Based Quality. Sustainable Price. Higher ROI.

Deviceless Remote Patient Monitoring

Traditional Remote Patient Monitoring

	Clinical Impact	Price per member
	↑	↑

	Clinical Impact	Price per patient
	↑	↓

Patient Engagement Campaigns

	Clinical Impact	Price per member
	↓	↓

	High Risk	**Rising Risk**	**Low Risk**
Relevant Patient Population	**0.5 – 5 %**	**20%**	**75%**
			
Financial Opportunity	$	$ $ $	$

CareSignal™

Why Deviceless RPM? Why *Now*?

Expand into areas of care, and quality, otherwise not financially feasible

Capture upside in at-risk contracts without sacrificing fee-for-service and telehealth revenues

Initiate 2021-2025 strategic objectives while slower movers lose ground post-COVID

CareSignal™

Deviceless Remote Monitoring
Accessible, Scalable, Clinically Actionable

CareSignal works for **any** patient

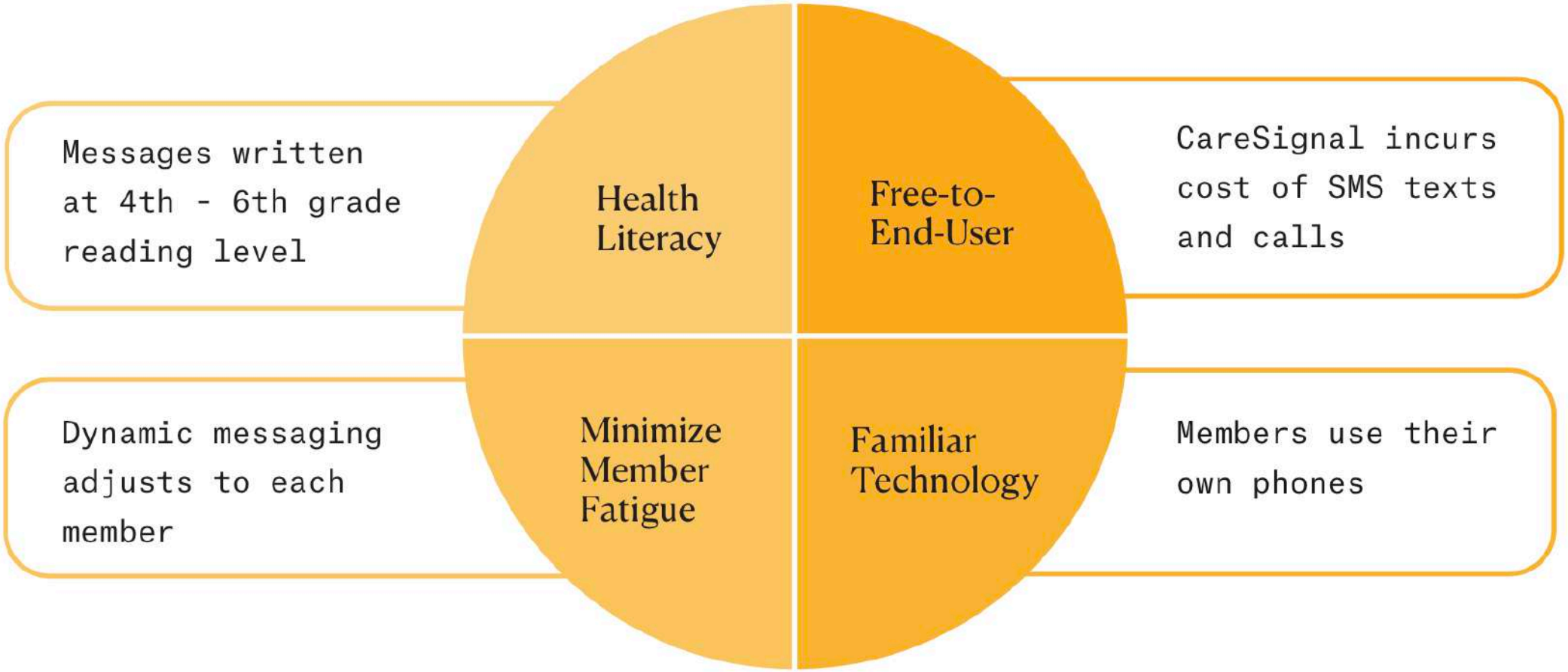
Via smartphone, pay-as-you-go phone, landline, or concerned caregiver's phone

10+

Publications in peer-reviewed journals

CareSignal™

Accessibility Is King
Technology, Process, & Patient Experience

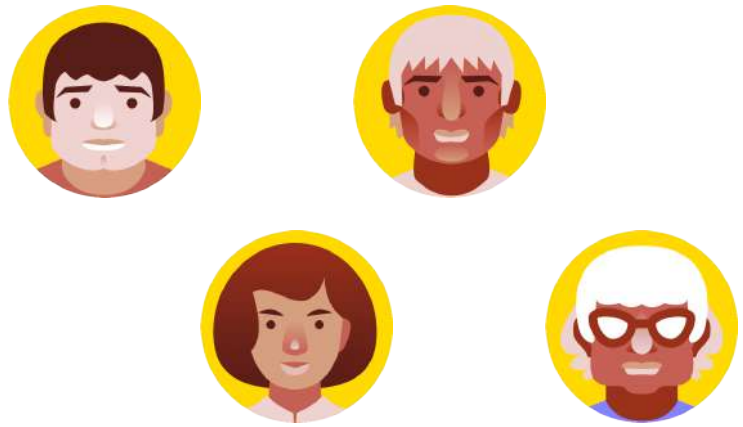


CareSignal™

Real-time Identification, Long-term Engagement

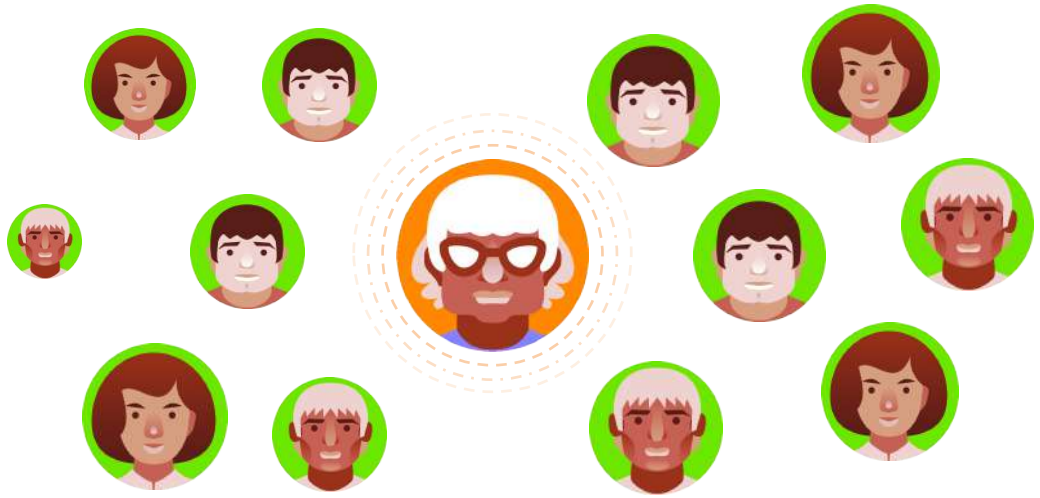
Scalable, cost-effective, top-of-license care management

Stratification before CareSignal:
Ex: all patients with CHF or COPD ICD-10



Retrospective data groups patients into broad risk pools requiring **manual outreach** to triage

Stratification after CareSignal:
Ex: worsening dyspnea or pedal edema



Real-time patient-generated **"Rare Data"**, biometric/symptomatic data that provides **actionable** clinical information…**Triggered Alerts** for targeted intervention

CareSignal™

CareSignal Operational Excellence
Proven Enrollment, Engagement, Outcomes, and Scale

62% decrease in hospitalizations for patients with COPD

28% drop in PHQ-9 for patients with depression

1.15% drop in HbA1c over 4 months

>2.1x increase in follow-up appointment adherence

50% improvement in blood pressure control over 12 weeks

58% decrease in CHF ED visits

10 Publications
in Peer-Reviewed Medical Journals

NEJM Catalyst

nature SCIENTIFIC REPORTS

SAGE journals
The award-winning electronic journals platform

JMIR

JMIR

Telemedicine and e-Health
Mary Ann Liebert, Inc. publishers

CareSignal™

CareSignal Program Portfolio
30+ Condition-Specific Programs Available

Chronic Condition Management
- Diabetes
- Hypertension
- Heart Failure
- COPD
- Asthma
- Dialysis

Behavioral Health
- Depression
- Anxiety
- Substance Use
- Opioid Management
- Mood
- Caregiver support
- Social Determinants of Health

Maternal Health
- Breastfeeding
- Postpartum depression

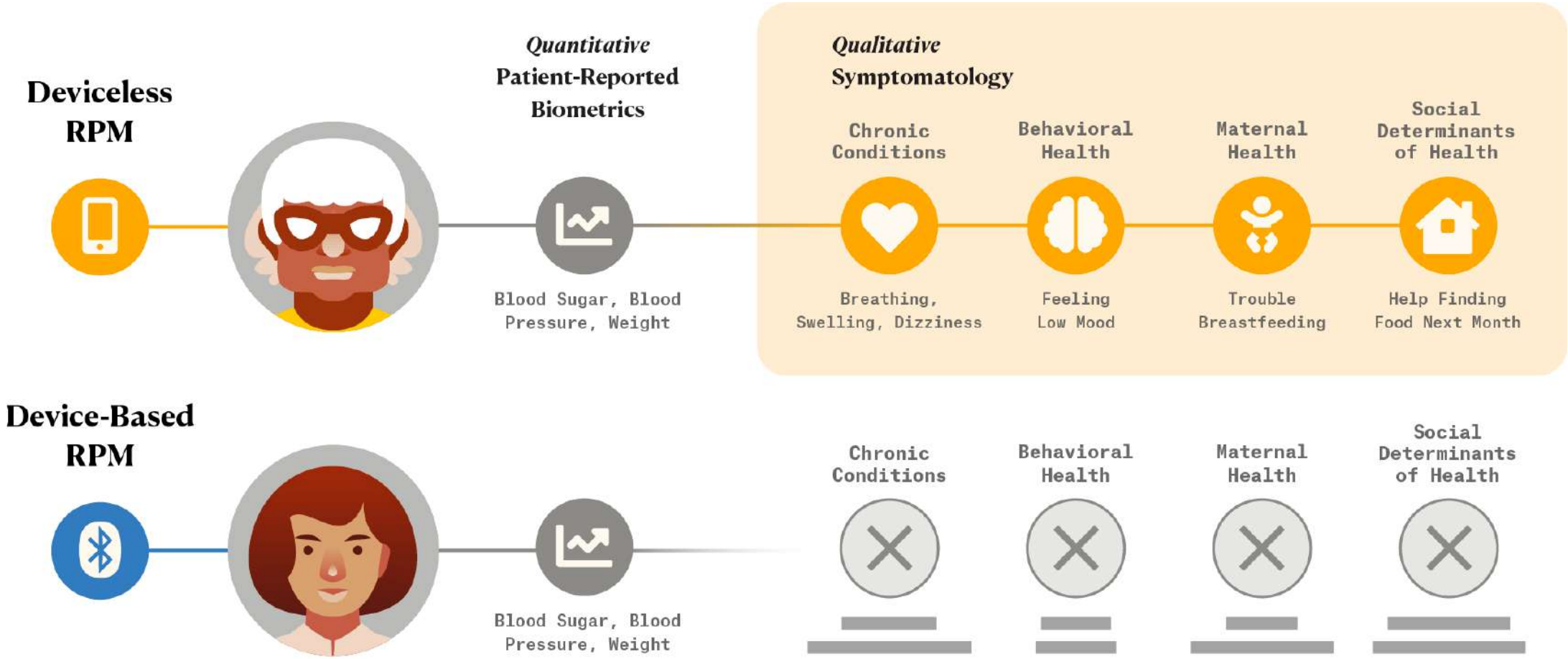
Discharge Support
- Appointment Reminder
- Post Discharge
- Referral
- Surgery
- Pneumonia
- Vital Signs

Screening Reminders
- Colorectal cancer
- Breast cancer
- Cervical cancer
- Diabetes ophthalmology
- Chlamydia screening
- Lead screening

Complementary Support
- COVID Suite
- Influenza
- Fall Risk
- Wellness
- Medication Tracking
- Medication Adherence
- Medication Companion

CareSignal™

Deviceless Remote Patient Monitoring *Scales Clinically Actionable Engagement Far Beyond Chronic Conditions*

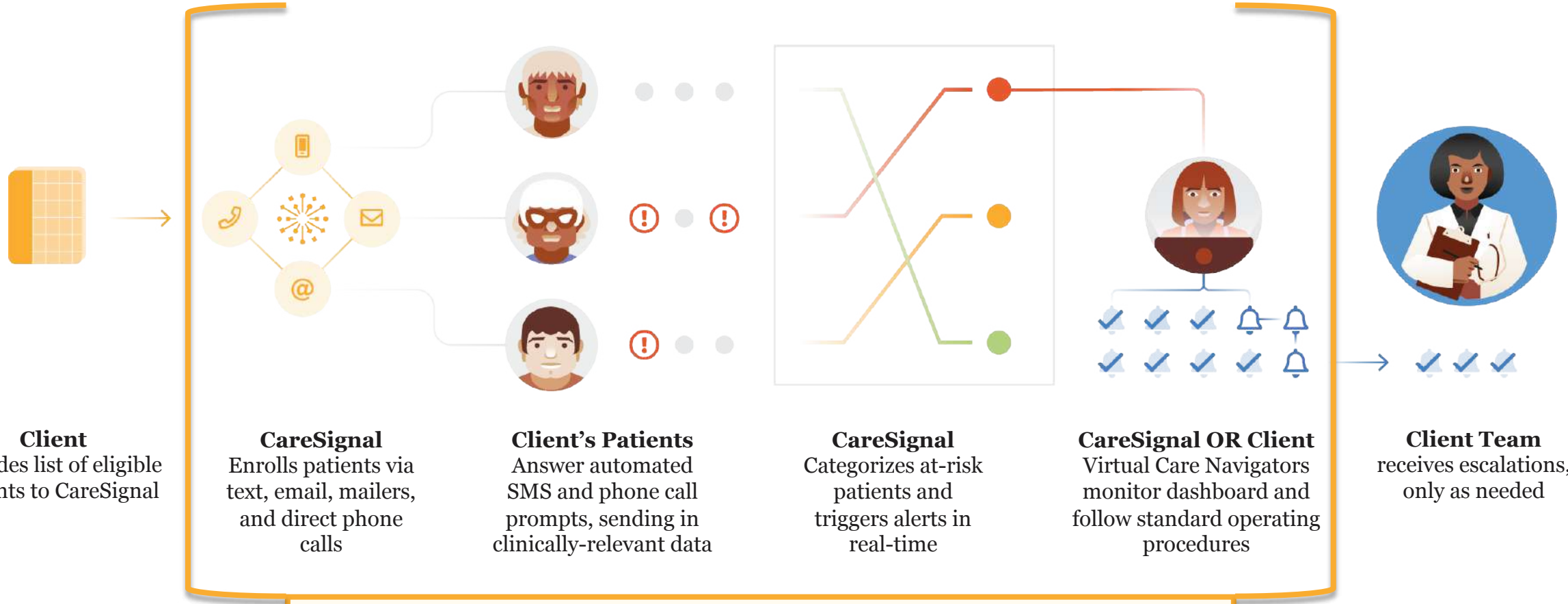


CareSignal™

Patient-reported outcomes are highly accurate, and the increased patient involvement promotes accountability across far more conditions

[1] https://onlinelibrary.wiley.com/doi/abs/10.1111/nmo.12466
[2] https://www.sciencedirect.com/science/article/abs/pii/S1072751515016178
[3] https://link.springer.com/article/10.1007/s40271-014-0090-z

CareSignal Member Journey
End-to-End Solution to Simplify Proactive Care



Client
Provides list of eligible patients to CareSignal

CareSignal
Enrolls patients via text, email, mailers, and direct phone calls

Client's Patients
Answer automated SMS and phone call prompts, sending in clinically-relevant data

CareSignal
Categorizes at-risk patients and triggers alerts in real-time

CareSignal OR Client
Virtual Care Navigators monitor dashboard and follow standard operating procedures

Client Team
receives escalations, only as needed

CareSignal manages everything between list generation & proactive notification

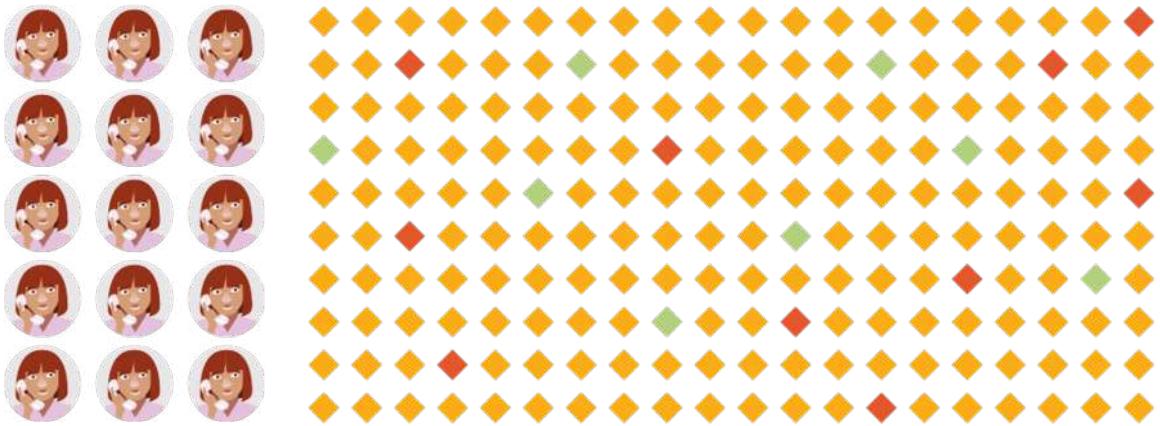
CareSignal™

Automated, engaging, and scalable programs are required to reach the tipping point for proactive care

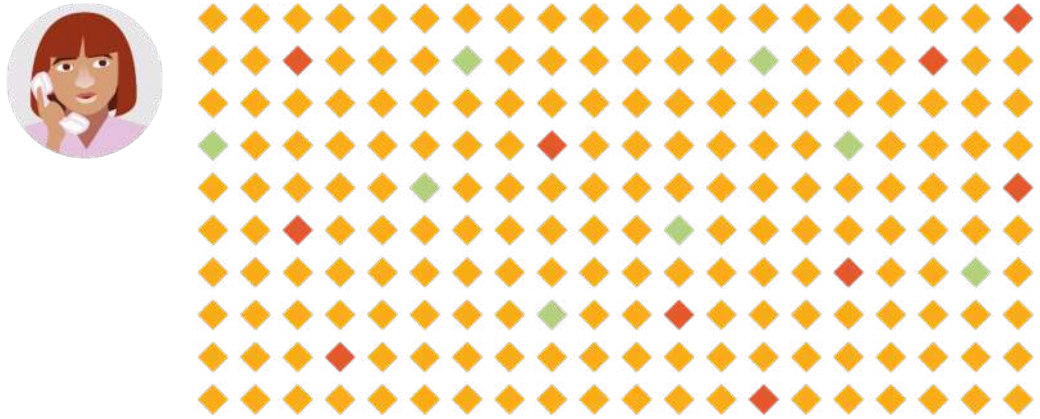
Manual outbound outreach limits case management impact and efficiency

Automated inbound insights allow case management to focus on the right members

15 Case Managers : 1,500 Patients



1 Case Manager : 1,500 Patients



CareSignal™

CareSignal.AI

Predict & Proactively Prevent Engagement Dropoff

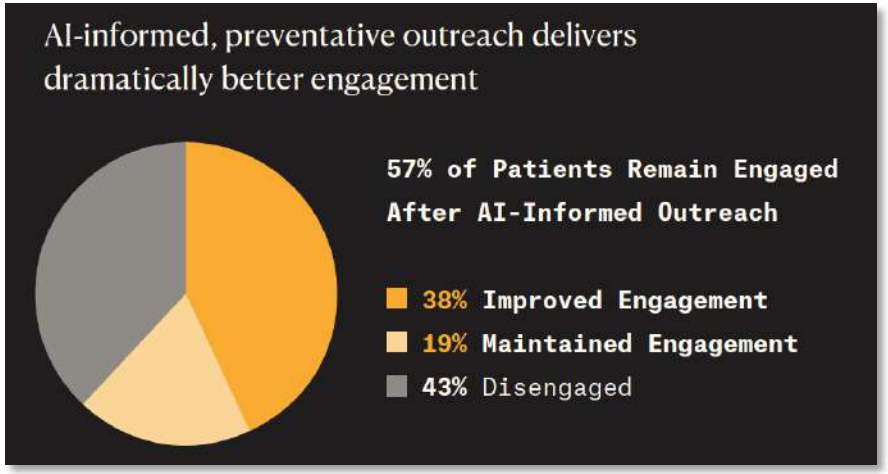
>50% 12-month retention

7,280,273+

Patient/Member days of data and metadata

16.62+

Lifetimes of care manager interactions



CareSignal™

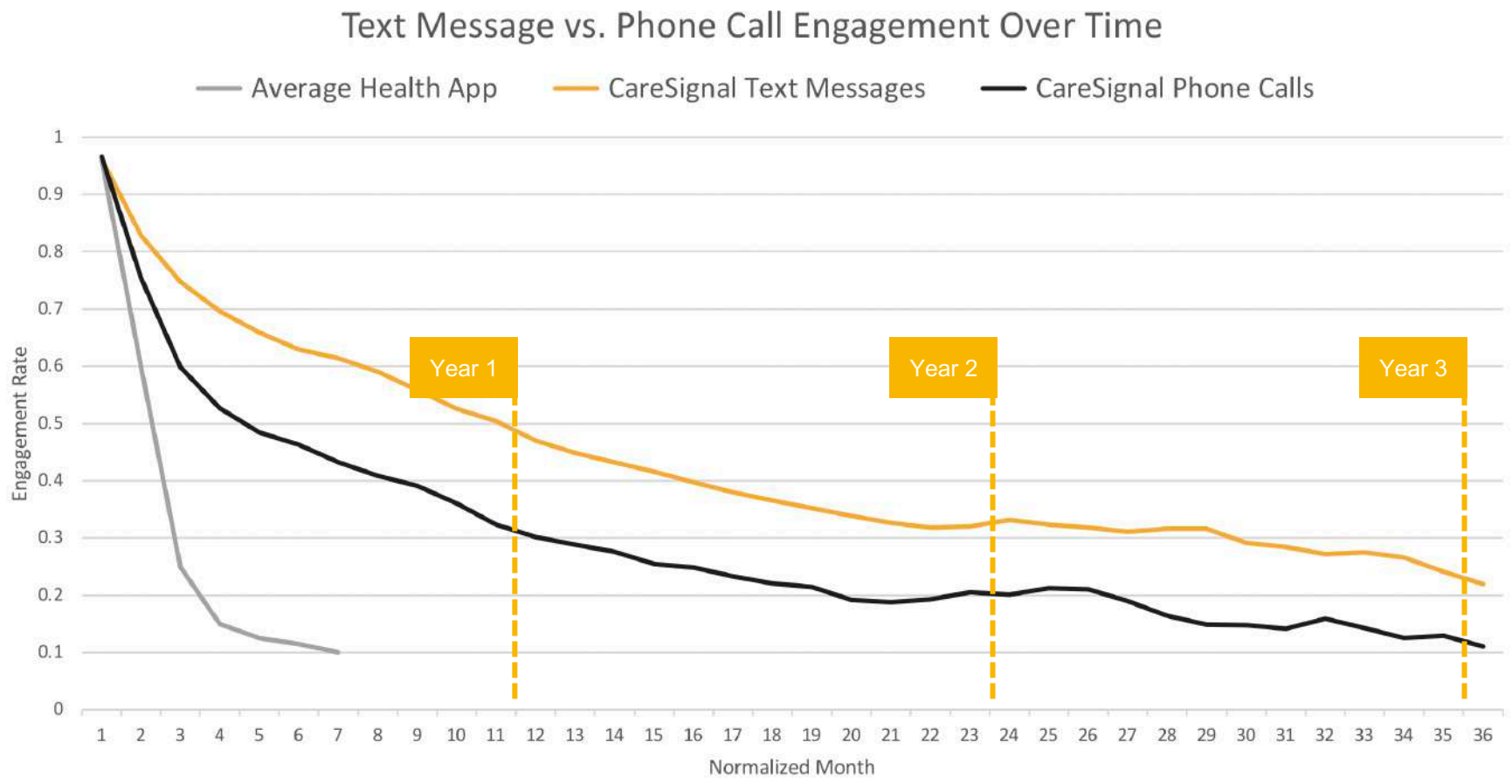
CareSignal Delivers Long-term Engagement

6x-12x Better Engagement & Retention Duration

Patient Engagement

1 in 2

Patients stay engaged 12 months or longer



CareSignal™

Mercy

Case Study

"CareSignal has created a technology that is simple to implement and produces a quick and sustainable impact on patient care. CareSignal allows Mercy to expand our ability to support patients with chronic conditions using a technology-first approach that allows nurse care managers to intervene when patients most need help.

Without this technology, nurses spent considerable time reaching out to patients in non-value-added activities that limited their ability to respond to patients at the right time. Now with smart technology, we can systematically reach out and connect with more patients on a routine basis and utilize our nurses to intervene when patients are beginning to have worsening symptoms.

This leads to a better patient experience, more targeted care management intervention, improved medication adherence, reduction in avoidable emergency department visits, and improved care manager and provider satisfaction."

- Mary Laubinger
Vice President, Population Health Navigation

Heart Failure

POPULATION

Employees diagnosed with CHF and a history of CHF-related ED visits prior to starting the intervention

CLINICAL OUTCOME

59%

reduction in CHF ED visits

HIGH LONGITUDINAL PATIENT ENGAGEMENT

57%

of patients were engaged at three months

33%

of patients were engaged at six months

FINANCIAL OUTCOME

-$848.20

per member per month

COPD

POPULATION

Employees diagnosed with COPD and a history of COPD-related ED visits prior to starting the intervention

CLINICAL OUTCOME

30%

reduction in COPD ED visits

HIGH LONGITUDINAL PATIENT ENGAGEMENT

54%

of patients were engaged at three months

39%

of patients were engaged at six months

FINANCIAL OUTCOME

-$193.85

per member per month

Diabetes

POPULATION

Employees diagnosed with diabetes

CLINICAL OUTCOME

2.03%

average reduction in HbA1C[1]

HIGH LONGITUDINAL PATIENT ENGAGEMENT[2]

89%

of patients were engaged at three months

78%

of patients were engaged at six months

FINANCIAL OUTCOME

-$200.71

per member per month

CareSignal™

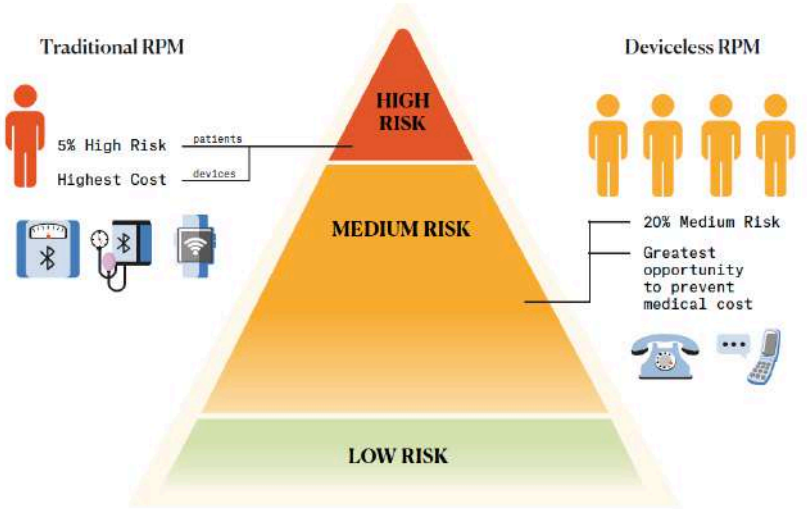
AMGA™
Advancing High Performance Health

Mercy presented outcomes at 2020 AMGA Conference

Large Medicare Advantage Physician Group (Fully Capitated)

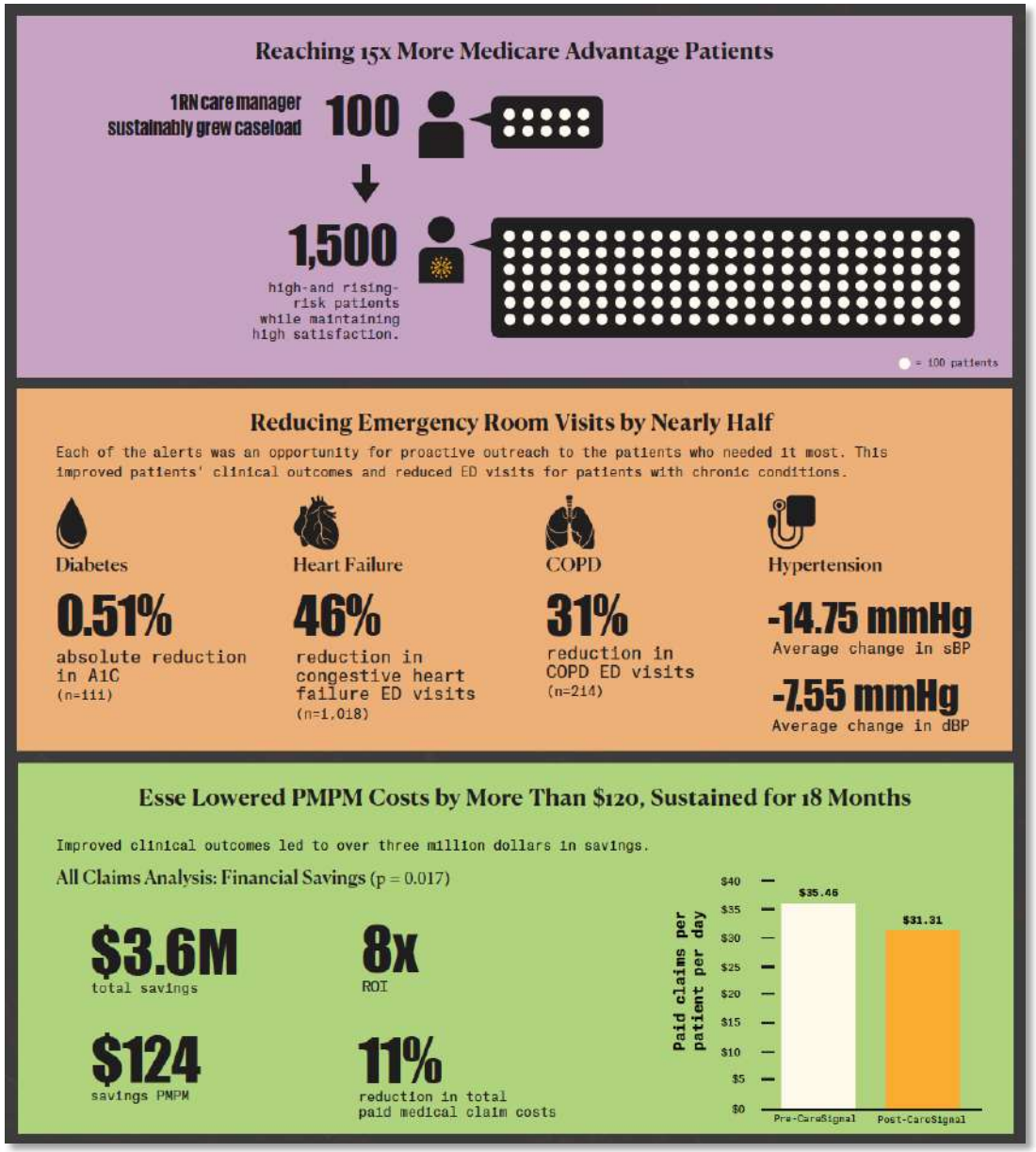
Case Study

Deviceless Remote Patient Monitoring Scales to Rising-Risk Patients at a Fraction of the Cost of Device-Based RPM



"Now we've been able to wrap our hands around a whole group of people who otherwise might not have gotten all those touches that they received with the platform. We've been able to scale the outreach dramatically without an increase in staff, and that's really important. High-risk care management is inherently a reactive model. By extending care management into the rising-risk patients, we are becoming more proactive. Now we can say, 'Hey, there might be a problem developing. Let's reach out to the patient instead of waiting until he goes to the ED.' It's helped us manage rising-risk patients who might not have perceived a need for a care management team before."

– Carla Beckerle
Vice President of Clinical Programs at Esse Health



CareSignal™

AMERICAN TELEMEDICINE ASSOCIATION

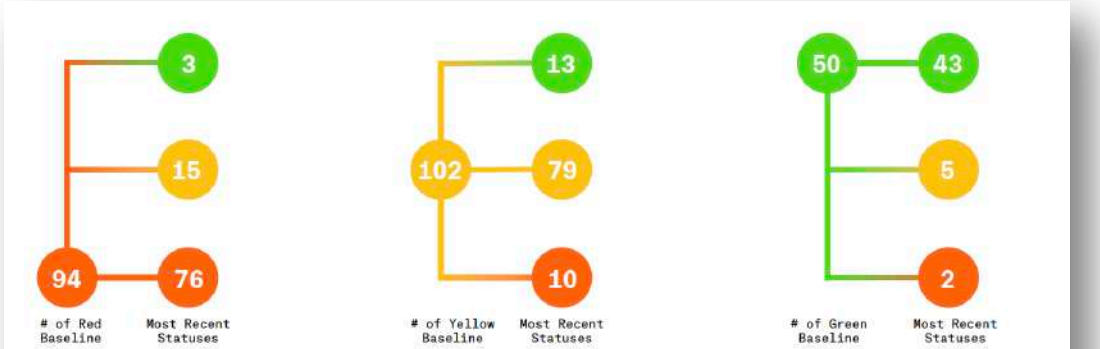
Presented outcomes at 2020 ATA & Abstract Published in Telemedicine and e-Health

STRIDE COMMUNITY HEALTH CENTER

formerly known as MCPN

Case Study

Condition	Quality Metric	Patient Inclusion Criteria
Diabetes	Reduce patient HbA1C levels to under 8%	HbA1C above 8%
Hypertension	Reduce patient blood pressure scores to under 140/90	BP above 140/90



Of 94 high-risk diabetes patients, 19% of them improved.

Of 102 rising-risk diabetes patients, 77% of them maintained.

Of 50 low-risk diabetes patients, 86% of them maintained.

Patients with diabetes reported:

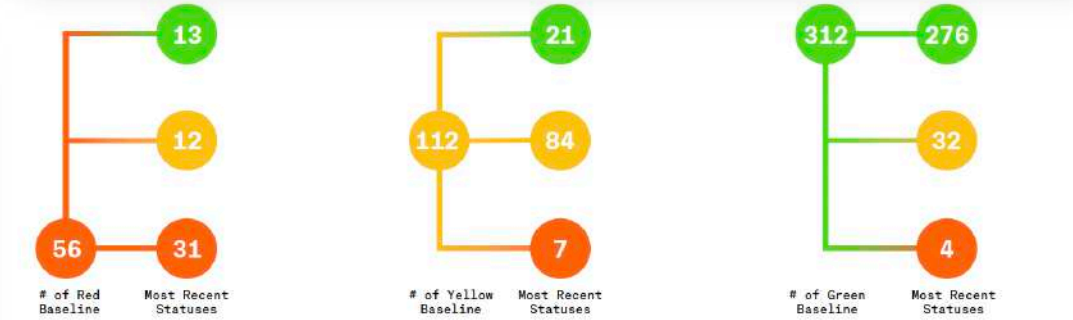
"This **helps me to be more responsible** in case I forget. I know you're going to send me a message, and it helps me to be prepared to answer."

"**I have more control with my diabetes**, and it helps me remember to take my blood sugar every day."

Patients with hypertension reported:

"It helps me to remember to take my medication. **I haven't forgotten to take it since** this service started."

"It **brings closeness between STRIDE and its patients**."



Of 56 high-risk hypertension patients, 45% of them improved.

Of 112 rising-risk hypertension patients, 75% of them maintained.

Of 312 low-risk hypertension patients, 88% of them maintained.

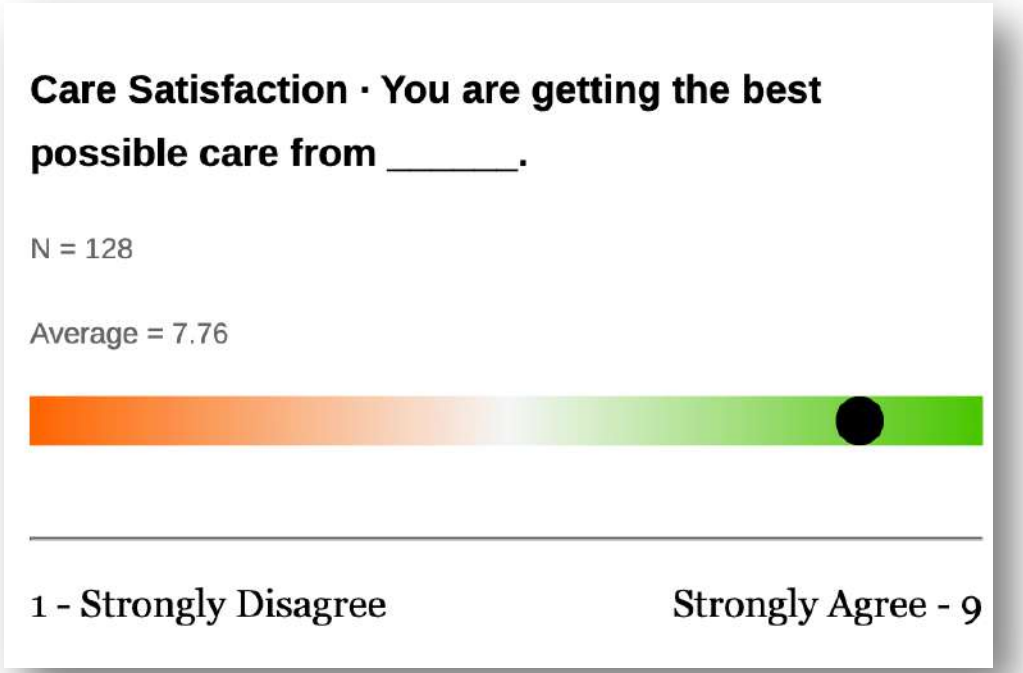
CareSignal™

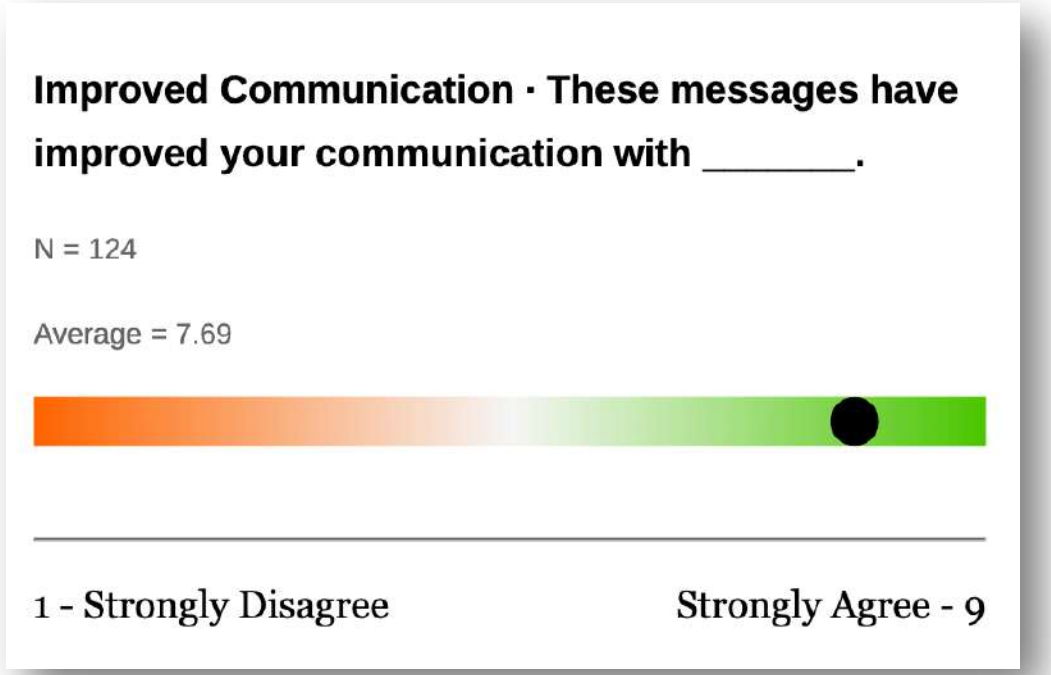
"CareSignal helps us engage hard-to-reach patients and see which patients are alerting, and sometimes, we find that they haven't been refilling their meds or haven't been to the clinic for over a year, and their blood pressure or blood sugar is out of control. CareSignal gives us way more visibility into our patient populations and allows us to reach out to patients and help."

- **Stephanie Campbell**, RN, director of nursing at STRIDE Community Health

Large Payer-Provider Joint Venture

Improve Satisfaction & Outcomes Simultaneously

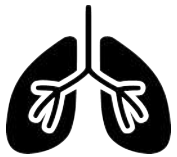




CareSignal™

Chronic Condition Programs

Diabetes
Monitors blood glucose levels and supply accessibility



COPD
Tracks breathing to prevent worsening symptoms

Heart Failure
Monitors heart health through tracking breathing, edema and weight

Hypertension
Tracks blood pressure and hypo- and hypertensive symptomology

Asthma
Monitors breathing with/without peak flow meter and tracks inhaler utilization

Dialysis
Monitors symptoms and tracks appointment/treatment adherence

Epilepsy
Tracks seizure frequency

CareSignal™

Behavioral Health & Sub Use Programs

Depression
Tracks mood and depressive symptoms via PHQ-9.

Substance Use
Monitors likelihood of relapse for patients in remission.

Opioid Management
Monitors pain level via PDI survey and tracks med consumption.

Caregiver Support
Monitors risk of caregiver burnout using IDT questionnaire.

Mood
Tracks general mood to help providers titrate medications.

Basic Needs/SDoH
Tracks patients' maintenance of basic needs.

GAD-7 (Anxiety)
Monitors anxiety symptoms using the GAD-7 scale.

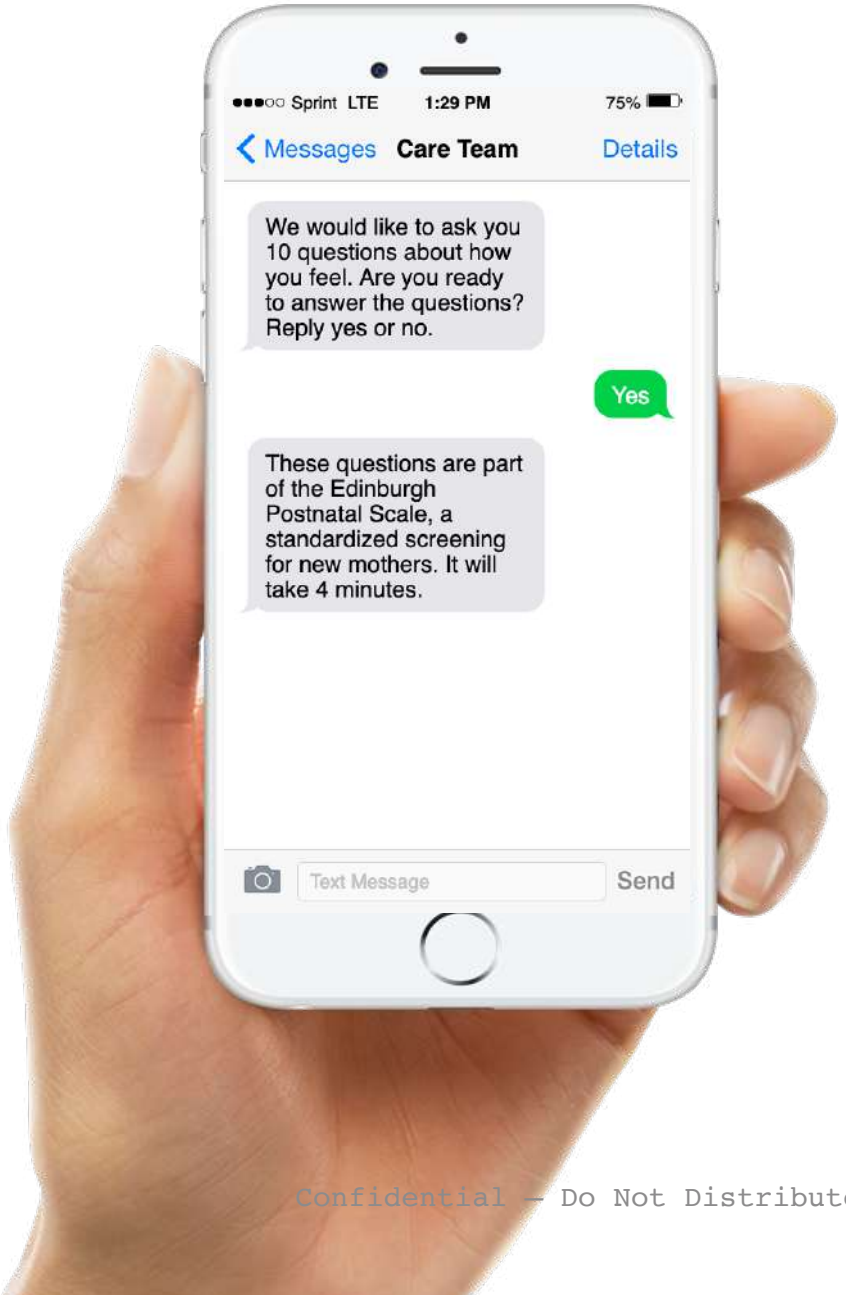
CareSignal™

Maternity Programs

Post Partum Depression
Series of 10 questions based on the Edinburgh Postnatal Depression Scale.

Breastmilk
Tracks breastmilk production and provides breastfeeding/pumping reminders.

Breastfeeding
Tracks breastfeeding habits and provides feedback and education.



CareSignal™

Complementary Support Programs

Fall Risk
Monitors patient's fall risk.

Wellness
Reinforces healthy diet and exercise habits.

Medication Tracking
Provides reminders and tracks reasons for missing medications.

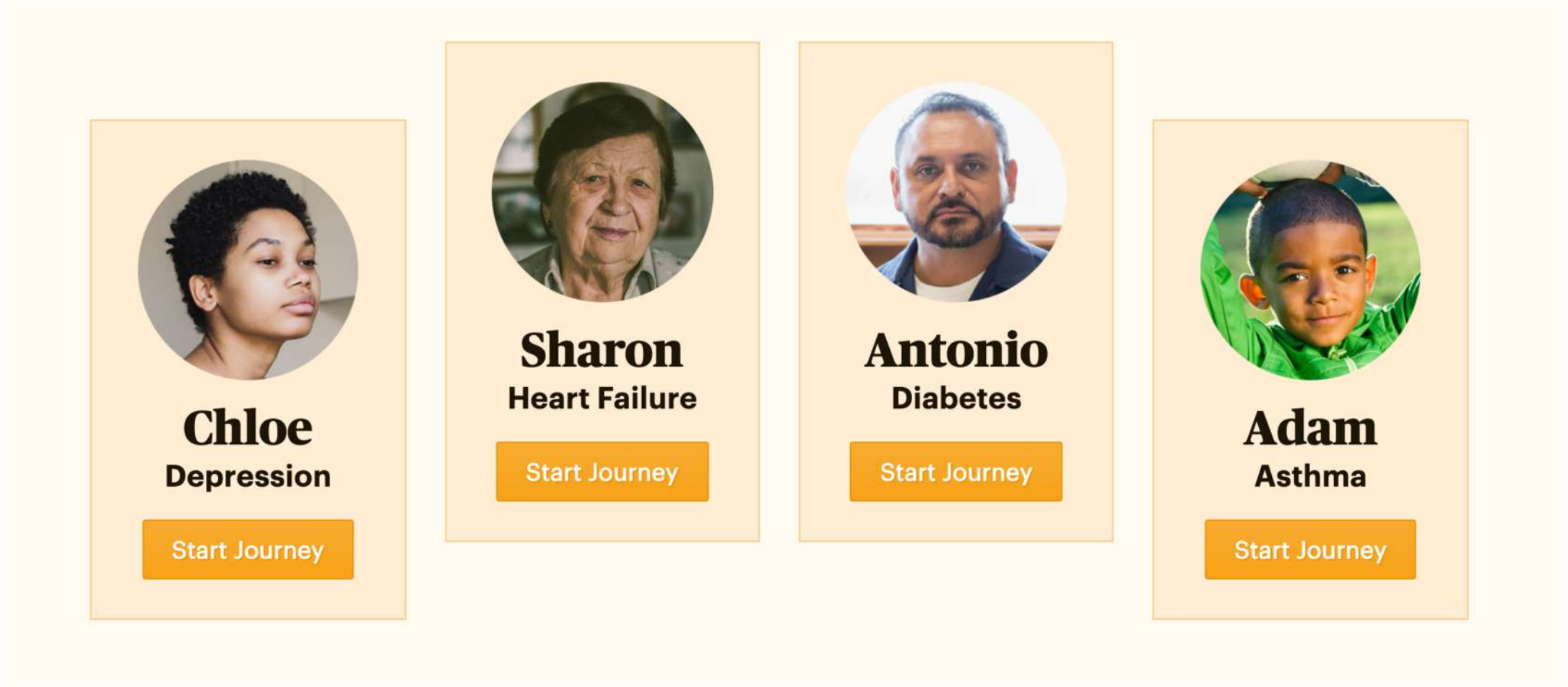
Medication Adherence
Tracks reasons for missing prescription refills.

Medication Companion
Tracks reasons for missing medications and prescription refills.

Vital Signs
Collects temperature, blood pressure, heart and additional vitals.

CareSignal™

Visit try.caresignal.health



CareSignal™

CareSignal®

Deviceless Remote Patient Monitoring

Thank You!

NeuGen
The Next Generation in Healthcare
Formerly WEA Trust

Case Study

Industry-Leading Engagement

75%

of members engage with and respond to CareSignal for at least 6 months

CareSignal™

Depression

2 in 3

members reported improved mental health

Hypertension

10.52 mmHg

average drop in sBP for members with baseline 140-160 mmHg sBP

COPD

100%

of respondents reported improved communication with WEA Trust

"**A key advantage of the WEA Trust is that they understand the needs of the members and the culture of our employees better than any other insurer.** In trying to develop a strategic plan to offer excellent benefits but also hold the line on costs, I believe WEA is an ideal partner to help design a strategy that will be effective in ensuring high levels of employee engagement."

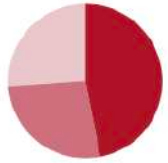
John Stellmacher
CFO, School District of Hartford Jt. #1

MOHAWK® INDUSTRIES, INC.

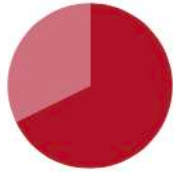
Case Study

“I like knowing that I have support when I feel my lowest. I love this service! It helps me keep track of my moods and to better communicate between my doctor and me.”

“This [program] has helped me remember to think about what I do to stay healthy and keep working and going.”



Generation
47% GenX
27% Baby Boomers
26% Other



Job Type
68% Manufacturing
32% Administration

Medication Adherence
>10% increase in self-reported adherence, from 70% to >80%. Refill data (MPR) averaged 86.5%.

Diabetes
13.7% average reduction in blood sugar in 19 weeks.

Hypertension
50% improvement in blood pressure control over 4 months.

Depression
28% average reduction in PHQ-9 scores in 11 months.

CareSignal™

Remote Monitoring: Detailed Comparison

	Classic Remote Patient Monitoring	Deviceless Remote Patient Monitoring™	Patient Engagement Campaigns
Patient Population	✗ High-Risk	✓ Rising-Risk	● Low-Risk
Clinical Impact	✓ High	✓ High	✗ Low
Price Per Patient	✗ High	✓ Low	✓ Low
Financial Opportunity	✗ Low	✓ High	✗ Low
Legend: Impact on ROI	✓ = Good	● = Neutral	✗ = Bad

CareSignal™

Remote Monitoring: Detailed Comparison

Classic RPM	Deviceless RPM™	Patient Engagement
• $100 Per Active Patient Per Month • Only feasible when billed • Requires patient implementation and training • Clinicians become tech support for patients • Appropriate for highest-morbidity populations	• Clinically actionable insights, keeping team top-of-license • Ready to scale immediately, with no patient-facing implementation or training • Proven ROI for patients, including > 20 chronic & behavioral conditions	• ≤$1 Per Active Patient Per Month • Highly automated, limited clinical value • Best used for relationship management and transactional interactions • Often customizable platforms with no content, clinical logic, SOPs or evidence of efficacy

CareSignal™

Large Payer-Provider Joint Venture

Message Frequency

Frequency Explained · Help us improve the message frequency. Why did you rate the message frequency as __?

Average = 1.86

1 - Too Few 5 - Perfect Too Many - 9

Message Frequency · Messages from _____ are sent at just the right frequency.

Average = 4.93

1 - Strongly Disagree Strongly Agree - 9

CareSignal™

CareSignal Operational Excellence
Proven Enrollment, Engagement, Outcomes, and Scale

Enrollment

1 in 4
Eligible patients enroll

Engagement

1 in 2
Patients stay engaged for >12 months

Scale

1,500+
Patients managed per care manager

10+ Publications
in Peer-Reviewed Medical Journals

62% decrease in hospitalizations for patients with COPD

28% drop in PHQ-9 for patients with depression

1.15% drop in HbA1c over 4 months

>2.1x increase in follow-up appointment adherence

50% improvement in blood pressure control over 12 weeks

46% decrease in CHF ED visits

CareSignal™

Partnership Testimonials

Patients

"The easy way to report the information without having to login in a computer. I get so busy at work I tend to forget to do it. ***This way is so easy****."*

"I feel safe because ***I feel that my doctor is next to me even thou I am 2 hrs away from him****. Different city."*

"It reminds me to test my sugars and to take my insulin. Helps keep me accountable. When my sugars spiked an actual person called to give me support. ***This may have saved my life****."*

"Mostly **I like keeping in contact with the Healthcare team without leaving home. I feel that I am protecting my health better by remaining in and not taking chances with the public**. I appreciate that my health concerns are being addressed in the safest way possible."

CareSignal™

Executives & Clinicians

"The entire team was wonderful. ***The most organized roll out of a project with an outside company*** *I have been involved with. Refreshing!"*

Chief Informatics Officer, Physician Group

"It's a ***great benefit to have a program that will assist patients,*** *especially patients who may not have family or friends who can check up on them on a regular basis".*

Care Manager, ACO

"Epharmix has ***improved the ability for our providers and care management staff to connect with our chronic disease patients****. It should help our patients achieve and maintain their treatment goals and allow us to identify patients needing an acute intervention to prevent ER and hospital visits."*

Medical Director, Top 5 Large Health System

*"****We had never had such a positive and supportive implementation partnership in such a short turnaround****. Everyone was respectful yet accountable and ensured success at every phase. Bravo!"*

Chief Clinical Officer, BH Network

Enrollment Performance

Physician Group Case Study

3,182
COPD & CHF

1,260
(40%)

Timeline: less than 4 months

CareSignal™

Recent Campaigns

	COPD 8,468 calls	CHF 8,216 calls
Outbound calls		
Success	91%	92%
Pick-up	50%	50%
Connection	87%	83%
Decision	71%	70%
Accept	71%	69%
Total per call conversion	19.6%	18.6%
Avg calls per patient ~2.1		

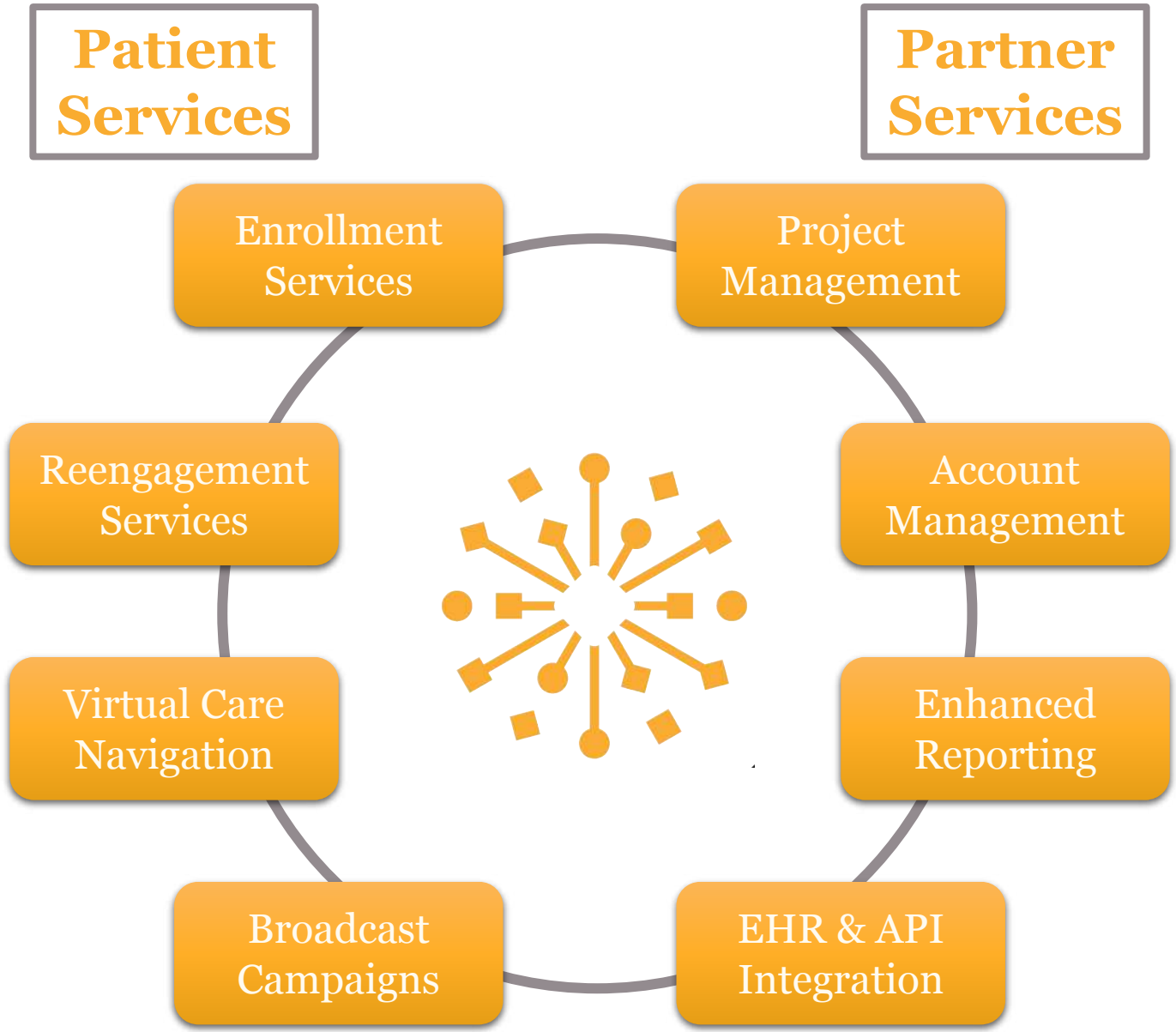
Beyond Technology: Supportive Services to Ensure Success

"The entire team was wonderful. ***The most organized roll out of a project with an outside company*** *I have been involved with. Refreshing!"*

Chief Informatics Officer, Physician Group

*"****We had never had such a positive and supportive implementation partnership in such a short turnaround****. Everyone was respectful yet accountable and ensured success at every phase. Bravo!"*

Chief Clinical Officer, BH Network

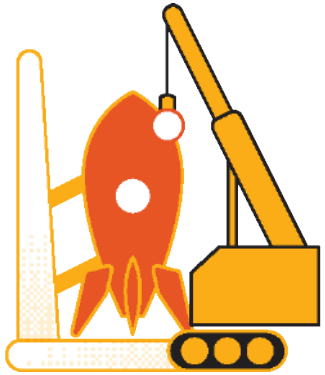


CareSignal™

Going Beyond Technology: Partnership Support

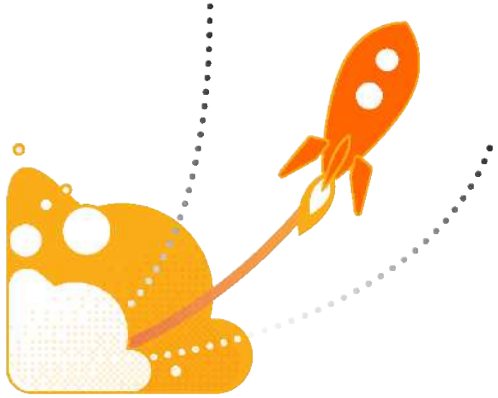
Kick-off

- Meet CareSignal team!
- Establish program goals
- Review project plan



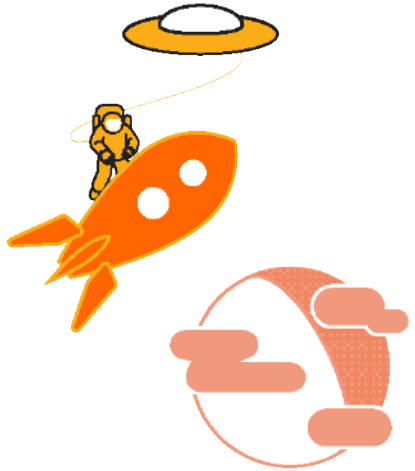
Onboarding

- Enrollment
- Operational workflows
- Clinical SOP's
- Training & Education



Ramp-up

- Patient Engagement Specialist increasing enrollment to target
- Check-ins every two weeks to streamline workflows

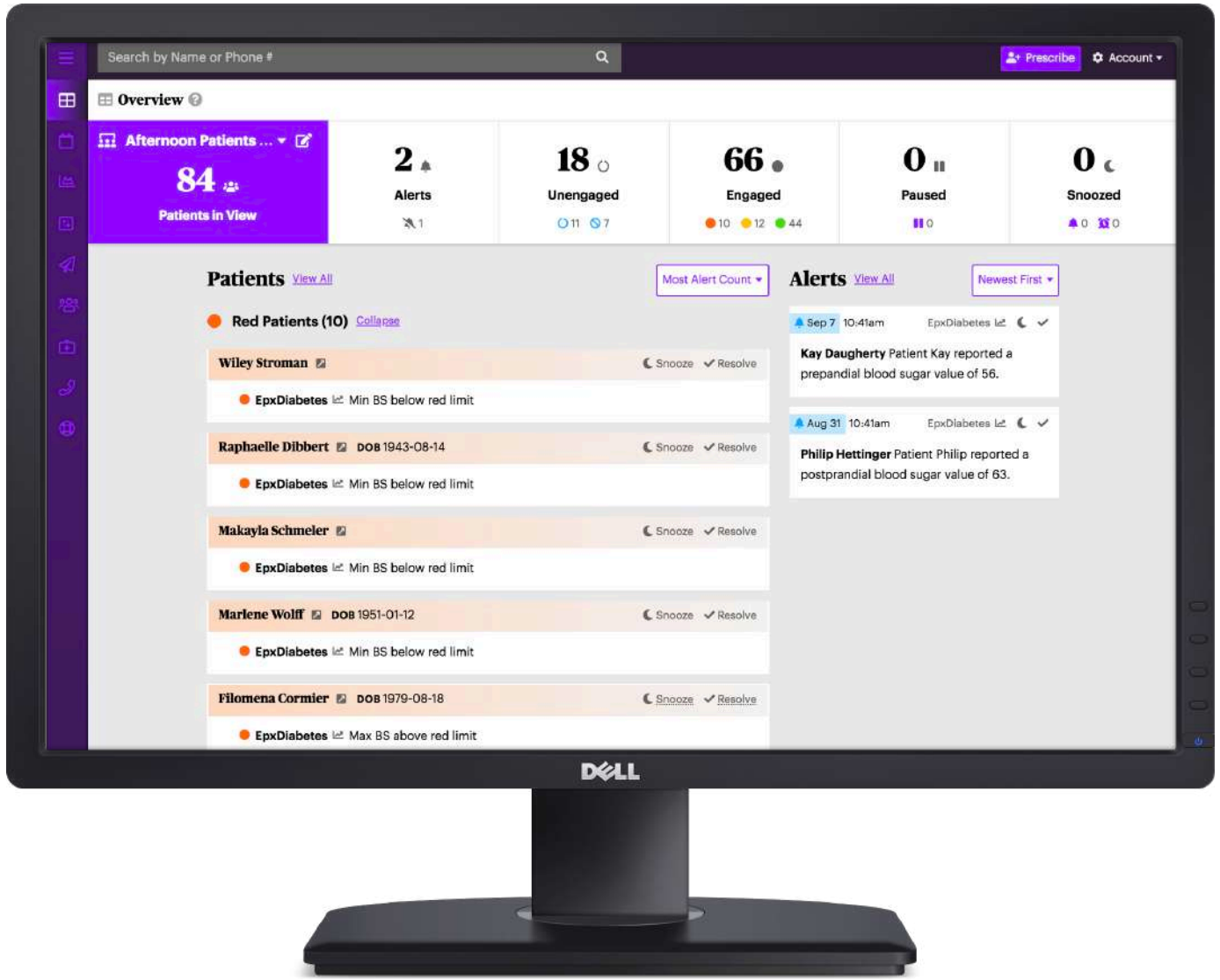


Ongoing Support

- Monthly utilization reviews
- Quarterly outcome reviews
- Accessible technical support
- Claims reporting available

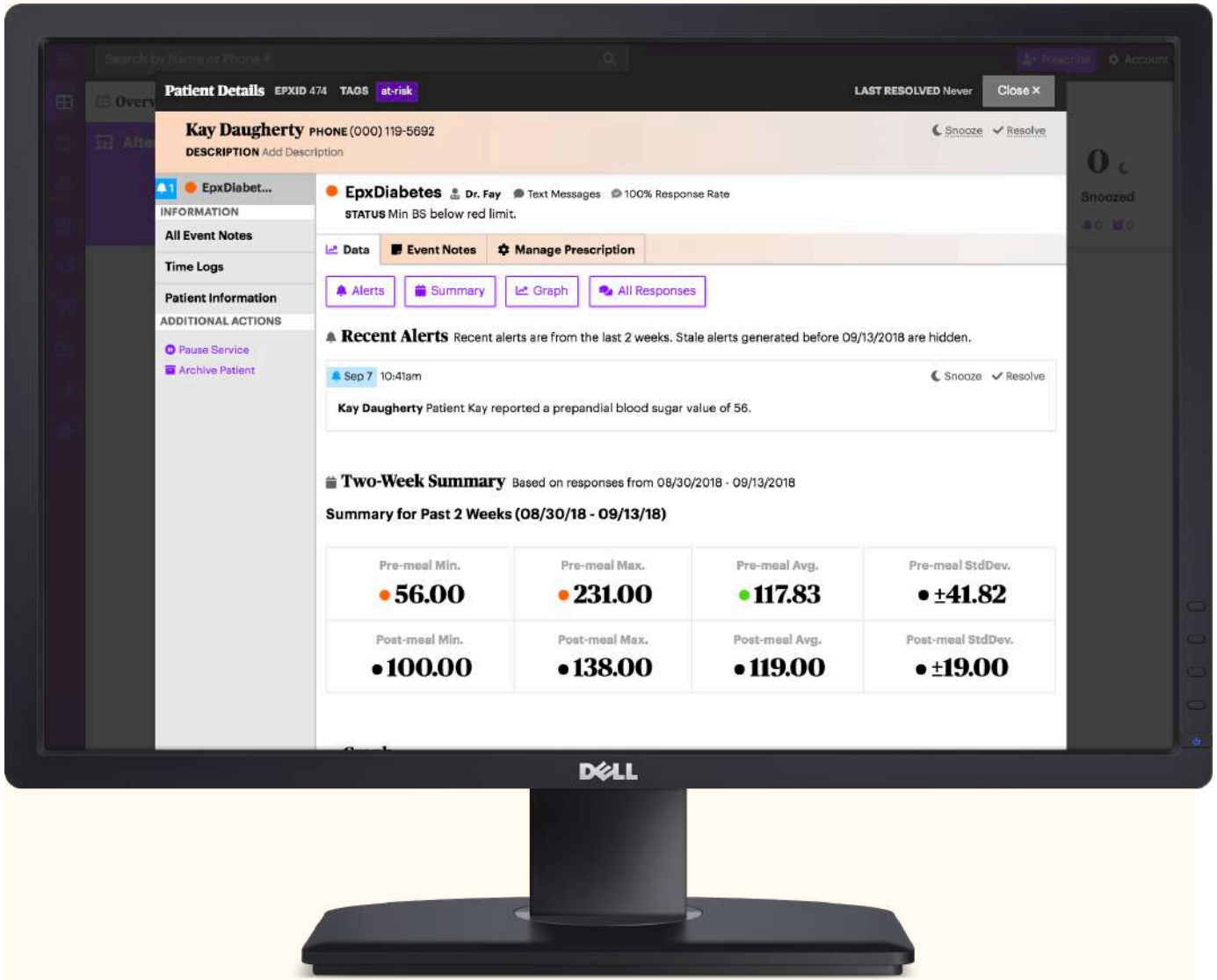
CareSignal™

Dashboard



CareSignal™

Dashboard



CareSignal™

Try COVID Companion now

Text HEALTH to 67634

COVID Suite Programs

For All Patients and Communities

COVID Companion

Share up-to-date CDC tips and local public health contact information at scale. Any patient or community member, regardless of infection status or provider affiliation, can use COVID Companion immediately.

For Patients Under Home-Quarantine

COVID Connect

Help patients in home quarantine self-monitor their key signs and symptoms, and enable automatic connection to your organization's existing COVID-19 hotline if any signs or symptoms worsen. Patients feel supported and informed, and you know they can reach out through the appropriate channel if necessary.

For Frontline or Clinical Staff

COVID Staff Support

Provide proactive support for frontline and clinical teammates This program sends simple daily health check-ins to monitor for any COVID-19 symptoms, and includes optional modules to track employee stress and any issues accessing PPE.

CareSignal™